

WID or SSN

DATE(S) OF CLAIMED INJURY

EMPLOYEE

VS.

EMPLOYER

AND

INSURER

AND

*Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.*

**TO THE WORKERS' COMPENSATION DIVISION, DEPARTMENT OF LABOR AND INDUSTRY**

1. The Objection to Discontinuance is filed in response to:

☐ An administrative decision issued under Minn. Stat. § 176.239 by \_\_\_\_\_ served  
Name of Judge

and filed on \_\_\_\_\_

or ☐ A Notice of Intention to Discontinue Benefits dated \_\_\_\_\_ (Check only if no administrative decision has been  
issued on this discontinuance.)

or ☐ Other \_\_\_\_\_

2. The employee alleges that he/she is entitled to the following additional benefits:

a. Temporary Total from \_\_\_\_\_ to \_\_\_\_\_

b. Temporary Partial from \_\_\_\_\_ to \_\_\_\_\_

c. Permanent Total from \_\_\_\_\_ to \_\_\_\_\_

3. Trial Data:

a. Requested place of: Pretrial \_\_\_\_\_ Trial \_\_\_\_\_

b. Estimated hours to present evidence: \_\_\_\_\_

c. If an interpreter is requested for a hearing or conference, specify the language/dialect: \_\_\_\_\_

d. If a reasonable accommodation of disability is requested for a hearing or conference, describe: \_\_\_\_\_

WHEREFORE, the Employee objects to the discontinuance of compensation benefits and requests that this matter be set for hearing in accordance with Minn. Stat. § 176.238.

EMPLOYEE SIGNATURE			ATTORNEY FOR EMPLOYEE SIGNATURE		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE			ATTORNEY REGISTRATION #	TELEPHONE	

STATE OF MINNESOTA }  
COUNTY OF \_\_\_\_\_ } ss.

## AFFIDAVIT OF SERVICE

I, \_\_\_\_\_, being first duly sworn, state that on \_\_\_\_\_, I served a true and correct copy of this document, enclosed in a properly addressed envelope, by depositing the same, with postage prepaid, in the United States mail at \_\_\_\_\_, Minnesota, addressed as follows:

### NAMES AND ADDRESSES

Subscribed and sworn to before me

this \_\_\_\_\_ day of \_\_\_\_\_

Notary Public \_\_\_\_\_

My Commission expires \_\_\_\_\_

\_\_\_\_\_  
Signature

### INSTRUCTIONS

1. The hearing will be expedited if the Objection to Discontinuance is within 60 calendar days after a Notice of Intention to Discontinue Benefits has been filed (if no administrative decision has been issued) or within 60 days after a decision concerning the discontinuance has been issued pursuant to Minn. Stat. § 176.239.
2. Failure to properly and fully fill out this form, with appropriate documentation, in accordance with workers' compensation rules of practice, is not considered proper filing. The Workers' Compensation Division may refuse to accept this form if it lacks any of the following: employee's name, date of injury, WID or social security number, or name of employer/insurer.
3. The claim must be presented in terms of the Minnesota Workers' Compensation Act.
4. If you have more defendants or more injuries than can be listed, this form may be modified accordingly.
5. A doctor's report or other information supporting the claim MUST be filed with this form.
6. A copy of this form must be served on the employer and the insurer, their attorney, potential intervenors, and the Special Compensation Fund, if applicable, by first class mail or personally.

***This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.***

**ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.**